### **NEVADA STATE BOARD OF MEDICAL EXAMINERS**

9600 Gateway Drive Reno, NV 89521

Rachakonda D. Prabhu, M.D. Board President Edward O. Cousineau, J.D. Executive Director



## \* \* \* M I N U T E S \* \* \*

### OPEN SESSION BOARD MEETING

Held in the Conference Room at the Offices of the Nevada State Board of Medical Examiners 9600 Gateway Drive, Reno, Nevada 89521

and Videoconferenced to

the Conference Room at the Offices of the Nevada State Board of Medical Examiners/Nevada State Board of Dental Examiners 6010 S. Rainbow Boulevard, Building A, Suite I, Las Vegas, Nevada 89118

### WEDNESDAY, AUGUST 8, 2018 - 12:00 NOON

Board Members Present at Board Olfice in Reno None

Board Members Present at Board Office in Las Vegas Rachakonda D. Prabhu, M.D., President Ms. Sandy Peltyn Victor M. Muro, M.D.

Wayne Hardwick, M.D., Vice President Weldon Havins, M.D., J.D.

Mr. M. Neil Duxbury, Secretary-Treasurer
Ms. April Mastroluca
Aury Nagy, M.D.
Michael C. Edwards, M.D., FACS

(NSPO Rev. 6-18) L-35

#### Staff/Others Present at Board Office in Reno

Edward O. Cousineau, J.D., Executive Director Aaron Bart Fricke, J.D., Deputy General Counsel Laurie L. Munson, Chief of Administration and Information Systems

Staff/Others Present by Telephone
Henna Rasul, J.D., Senior Deputy Attorney General

## Agenda Item 1 CALL TO ORDER AND ANNOUNCEMENTS

Roll Call/Quorum

The meeting was called to order by President Rachakonda D. Prabhu, M.D., at 12:01 p.m.

Mr. Cousineau took roll call of the Board members present at the Board offices and those present via telephone. Board members not present were Mr. M. Neil Duxbury, Secretary-Treasurer, Ms. April Mastroluca, Aury Nagy, M.D. and Michael C. Edwards, M.D., FACS. Mr. Cousineau announced there was a quorum.

## Agenda Item 2 PUBLIC COMMENT

Dr. Prabhu asked whether there was anyone in attendance who would like to present public comment.

Robert Lauer said he joined the U.S. Army in 2005 and served in the Iraq war. He sustained a spinal injury and is disabled. Because of that, he is in the VA system. He stated the VA has been cancelling consults to specialists to keep services to veterans in-house and save money for the VA. He said this is not arbitrary or capricious; it is systematic, fraudulent, and is causing the deaths of veterans. He said that he, himself, has personally experienced this, and that U.S. Army veteran Stephen Carey died a year ago because of this specific practice by the VA. He also has a friend, a female veteran who served in the Air Force, who went into the ER the 13th of last month in severe pain, needed a steroid shot, and was given opioids for three or four weeks. Mr. Lauer said he filed a complaint with the Board in December of last year, on behalf of Stephen Carey against the VA, under the leadership of Dr. Komanduri, against doctors who are licensed by the Board. He said he hasn't heard anything in nine months; that neither he, nor the lawyers, nor the family of the dead veteran have been contacted. He wants to see the Board take action to make sure these doctors are held accountable. They are not doing their jobs. Dr. Komanduri will not, to this day, return a phone call to veterans who are distressed in the ER. He has been irresponsible and he needs to be replaced. Mr. Lauer said he was calling the Board to take action, to have Dr. Komanduri removed immediately and have someone else put in his place. Mr. Lauer said he was going to include in the record two stories he wrote, and also testimony from Shawna Carter, the female veteran, who was, that day, staying at home convalescing on opioids instead of getting an injection from the VA (Attachment 1). He said the public has a right to know what is going on.

### Agenda Item 3

CONSIDERATION OF REVOCABLE DELEGATION AND AUTHORIZATION BY THE BOARD TO THE GENERAL COUNSEL OF THE BOARD TO DEFEND THE BOARD'S FINDINGS, CONCLUSIONS, ORDERS AND ACTIONS IN THE MATTER OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS VS. CHARLES P. VIRDEN, M.D., BME CASE NO. 16-10736-2, AND DISTRICT COURT CASE NUMBER 18 OC 00016 1B, IN ANY CIVIL OR CRIMINAL PROCEEDING, STATE OR FEDERAL, THAT IMPLICATES THE BOARD'S ADJUDICATION OF THIS CASE, TO PARTICIPATE IN, DEFEND AGAINST, OR TO INITIATE ON ITS BEHALF ANY PETITION FOR JUDICIAL REVIEW OR APPEAL THEREFROM, TO FILE A NOTICE OF APPEAL OR STATEMENT OF INTENT TO PARTICIPATE ON ITS BEHALF, TO NEGOTIATE AND SETTLE CLAIMS ON ITS BEHALF, AND TO TAKE COMPARABLE ACTIONS AND MAKE COMPARABLE DECISIONS ON ITS BEHALF

Mr. Fricke explained that due to the recent decision in the Nevada Supreme Court case of *Nevada Commission on Ethics vs. Ira Hansen and Jim Wheeler*, Board legal staff was requesting revocable delegation and authority to defend the Board's Findings of Fact in this district court case and in all related cases.

Dr. Muro moved that the Board approve a revocable delegation and authorization as outlined on the Agenda. Ms. Peltyn seconded the motion, and it passed unanimously.

#### Agenda Item 4

CONSIDERATION OF REVOCABLE DELEGATION AND AUTHORIZATION BY THE BOARD TO THE GENERAL COUNSEL OF THE BOARD TO DEFEND THE BOARD'S FINDINGS, CONCLUSIONS, ORDERS AND ACTIONS IN THE MATTER OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS VS. JOEL WASHINSKY, M.D., BME CASE NO. 10-8162-1, AND DISTRICT COURT CASE NUMBER A-18-7772233-S, IN ANY CIVIL OR CRIMINAL PROCEEDING, STATE OR FEDERAL, THAT IMPLICATES THE BOARD'S ADJUDICATION OF THIS CASE, TO PARTICIPATE IN, DEFEND AGAINST, OR TO INITIATE ON ITS BEHALF ANY PETITION FOR JUDICIAL REVIEW OR APPEAL THEREFROM, TO FILE A NOTICE OF APPEAL OR STATEMENT OF INTENT TO PARTICIPATE ON ITS BEHALF, TO NEGOTIATE AND SETTLE CLAIMS ON ITS BEHALF, AND TO TAKE COMPARABLE ACTIONS AND MAKE COMPARABLE DECISIONS ON ITS BEHALF

Mr. Fricke explained that, similar to the last item, Board legal staff was requesting revocable delegation and authority to defend the Board's Findings of Fact in this district court case and in all related cases.

Dr. Muro moved that the Board approve a revocable delegation and authorization as outlined on the Agenda. Dr. Hardwick seconded the motion, and it passed unanimously.

## Agenda Item 5 PUBLIC COMMENT

Dr. Prabhu asked whether there was anyone in attendance who would like to present public comment. No public comment was received.

## Agenda Item 6 ADJOURNMENT

Dr. Muro moved to adjourn the meeting. Dr. Hardwick seconded the motion, and it passed unanimously. Dr. Prabhu adjourned the meeting at 12:11 p.m.

\* \* \* \* \* \*

### Attachment 1

### AGENDA ITEM 2 PUBLIC COMMENT

### DOCUMENTS SUBMITTED BY ROBERT LAUER



August 5, 2018

#### Rob Lauer Political Reporter, U.S. Army Veteran

If one wants to understand why so many veterans are committing suicide it's easy to see why when one hears Air Force Veteran Shawna Carter's story. When veterans are forced to suffer in pain, when veterans' cry for help are ignored by VA doctors like Chief of Staff Dr. Komanduri, when veterans can't get government agencies like the VA and the NV Medical Examiners Board to hold anyone accountable for their suffering, one can see why many Veterans feel hopeless and kill themselves.

On December 20, 2017 a formal complaint was filed with the Nevada Medical Examiners Board against Dr. Ramu Komanduri, **Chief of Staff** of the VA Southern Nevada Health Care System in the death of Army Veteran Stephen Carey. Dr. Ramu Komanduri is a Nevada licensed doctor, which means the State of Nevada Medical Examiners Board is responsible for regulating and overseeing his competence and performance. Stephen T Carey was 42 years old last year when he died from Stage 4 cancer all alone in his mother's basement. Stephen's destiny was cast in stone, according to a lawsuit filed recently against the VA for Malpractice, when VA doctors failed to test and diagnose renal cancer back in 2011 through 2015 on 3 separate occasions. Carey's death stemmed from a cost savings practice at the VA where nurses and non-licensed medical staff cancel consults after Licensed Medical Doctors who've examine veterans issue referrals (consult) to a specialist.

Eight months after that formal complaint was filed against the Southern Nevada Chief of Staff Dr. Komanduri with the Nevada State Board of Medical Examiners, no visible action has been taken. And what's worse is there's been no change in the culture and treatment of Veterans by our local VA hospital. While the doctors and nurses are often over worked and under paid, most try their best under poor leadership and disastrous management.

2 of 13 8/8/2018, 10:06 AM

I say disastrous because when you hear what many Veterans continue to endure after all the rhetoric, you can start to understand the needless suffering many Veterans are forced to endure that lead so many take their own lives.

I have a female veteran friend, Shawna Carter, who has been suffering in severe pain for weeks and the VA refuses to properly treat her. She first went the VA ER in mid July seeking help. She has been in and out of the ER where they do little for her but give her opioids instead of the steroid injection she really needs. She was just told she needs to wait another 7 weeks to get treatment. She called Dr. Komanduri's office seeking assistance only to be ignored. Again, Dr. Komanduri is the chief of staff Doctor at the Southern VA Medical Center. She needs an epidural Steroid injection. Outside pain clinics have same day treatment available, but the VA refuses to pay instead forcing her to wait 10 weeks.

The leadership in the Southern Nevada VA and the VA in general openly oppose and are undermining President Trump's efforts to reform the VA and allow Veterans to seek medical treatment from outside medical providers. For example, under current rules, if a veteran cannot be seen at the VA within 30 days for treatment they can go to an outside provider. But the VA bureaucracy actively undermines those rules by canceling referrals to outside providers "consults" then starting over the process for frivolous reasons in order to stretch out the 30 period to keep the Veteran in house. Or the VA forces a veteran like Shawna to see her general care doctor first to get a consult to a specialist, even if they are in the VA ER. This often turns the 30 day wait into 60 to 90 days. There's no reason a VA ER doctor cannot refer a veteran directly to a specialist for care.

What's worse is the VA has refused to turn over documents about how many Veterans' consults they cancel each year, even after the Southern VA was served with a Freedom of Information Request by this news outlet.

Fundamental change has failed to take hold at the VA. So it's time the Nevada Medical Examiners Board hold Nevada licensed Doctors, like Dr. Komanduri, accountable for failing to provide responsible and humane care for Veterans like Shawna.



Air Force Veteran Shawna Carter, mother

### Shawna's Struggle to get help from the VA in her own words:

I left messages with people at every level of the hospital and have even spoke with Senator Heller's office too.

I feel like it is a policy problem. We are supposed to get care in a timely manner, and as long as they can get us an appointment in 30 days, they are following policy. However, the 30 day window isn't necessarily for care.

So, I went to the ER on the July 13th for what looked like strep, I never received a call confirming or denying. I also complained of joint pain flare ups from my ankylosing spondylitis and the associated migraines. Because I had an appointment the following week with my rheum, they said follow up with him. He agreed that I would need the epidurals again and put in a consult with the pain clinic on the 20th. They called to let me know they could get me an appointment on the August 15th, and according to them, this is acceptable because the consult wasn't put in until the 20th of July. I argued that I was seen a week prior in the ER and that I would not be receiving care in 30 days. I expressed my concern with the length of time it would take to get care, because even if I was seen for a consult on the 15th, they are likely booked out another 3 weeks for procedures. They can, and have previously, sent me to an outside care provider and they have had the consult and treatment done in 2 days.

I also followed up with my neurologist on the 25th regarding the associated migraines. I needed meds for breakthrough migraines. In the past I was given fioricet which worked fabulously and a prescription of low quantities typically lasts at least a year. Yet the pharmacy denied the doctors request because their system says

fioricet is for tension headaches, not migraines. The doctor was trying to get me to say I had tension headaches just to get the proper meds. I shouldn't have to falsify my medical records because their policy changed. The 'neuro offered me many other options that I have tried in the past but didn't work. Keep in mind, when I have break through migraines that I can't treat at home, i go to the ER where they hit me with morphine (which no longer works), or dilaudid. So, they would rather me have to come get admitted into the ER when I can easily treat the condition at home.

When I was denied medication, I proceeded to my 2nd ER visit where they drew blood and told me there was nothing they could do. They tried to discharge me, but I refused to leave. I contacted the Chief of staff's office, the director of the hospital's office, patient advocacy, the pain clinic's office manager, and the senator's office. The only one that called back was the senator's office. I was advised to attempt to make an appointment with the pain clinic I was previously seen at and ask them to put in a secondary authorization. That was denied by the VA, because they could get me in for a consult within 30 days. Not for treatment.

I was back in the ER on August 1st too. They gave me pain meds (norco) and anti-inflammatory (meloxican). This was an outside hospital, not the VA. So, with the opioid crisis and what we are trying to get away from, it seems that they would rather chance getting someone addicted to pain meds because of a lack of accurate and timely care. It costs \$400-600 to pay for these injections with an outside provider, and they can be done in 2 days, how much do all these ER visits, and specialist visits cost? Plus all the meds they have been administering and sending me home with that are not effective? Surely it is not cost effective to drag the process out.

The pain clinic called yesterday and I asked them to schedule the procedure now so I don't have to wait another 3 weeks after the consult. Apparently they aren't supposed to do that either, but the lady I spoke with heard the desperation in my voice and asked the doctor to hold an appointment on the 20th for me for a procedure.

The doctors have given me notes to be off work for 5 weeks! 90% disabled vet pay does not even come close to covering my monthly bills, so I have to work, yet am not able to because I can't control my pain with anything other than pain pills, and I can't work or drive while on them. It is no wonder we have so many homeless vets and veteran suicides. The VA forces us into a state of hopelessness where we are left for the pain to take over. I don't want to become a statistic because of their negligence.

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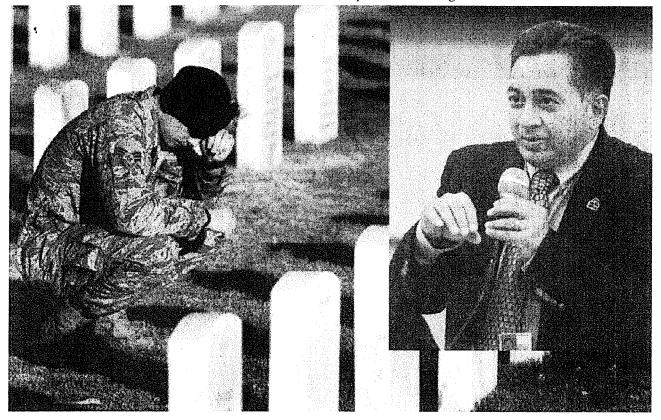




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# **NEED CASH NOW?**





### December 20, 2017

Today, a formal complaint was filed with the Nevada Medical Board against Dr. Ramu Komanduri, **Chief of Staff** of the VA Southern Nevada Health Care System in the death of Army Veteran Stephen Carey. Stephen T. Carey was 42 years old last year when he died from Stage 4 cancer all alone in his mother's basement. Stephen's destiny was cast in stone, according to a lawsuit filed recently against the VA for Malpractice, when VA doctors failed to test and diagnose renal cancer back in 2011 through 2015 on 3 separate occasions.

The death stemmed from a cost savings practice at the VA where nurses and non-licensed medical staff cancel consults after Licensed Medical Doctors who've examine veterans issue referrals (consult) to a specialist. This practice by the VA is a direct threat to the lives of Veterans. The practice is done with reckless disregard to the current health issues and needs of Veterans in order to save money for the VA. Dr. Komanduri, Chief of Staff of the VA Southern Nevada Health Care System has full knowledge of this practice that has led to deaths and further damage to patients through unnecessary delays.

According to this Veteran, Dr. Komanduri refuses to take calls from Veterans with medical issues and delays in care. He has shown a total disregard for the health and well being of veterans under his care.

According to outside urologist, Dr. Kelly, who reviewed Stephen's case, "There were three separate occasions during which time Stephen could have been diagnosed with renal cancer carcinoma... during that time in which Stephen's cancer could have been diagnosed and *most likely cured* was ultimately fatal to his survival."

### Direct from the Complaint filed with the Nevada medical review board:

Affidavit of Mark J. Kelly, M.D.

On January 3, 201 1 (Monday) at approximately 1:23 a.m., Mr. Cary presented himself to the emergency room of the Mike O'Callaghan Federal Hospital at Nellis Air Force

Base in Las Vegas, Nevada ("Nellis Federal Hospital"). According to the hospital's intake sheet, Mr. Cary's chief complaint was "blood in urine." Emergency room staff noted that Mr. Cary told them he had been "peeing straight blood" and that it had "started Friday night." Dr. Phil Goebel, M.D., the attending physician that morning, ordered an emergency, noncontrast CT scan to be performed upon Mr. Cary. The test results revealed a solid lesion in his kidney and concern was appropriately focused at that time on the possibility that this lesion represented renal cell carcinoma. Mr. Cary's results were interpreted that same morning, at approximately 5:29 a.m., by Valor Teleradiology. Dr. Goebel appropriately recognized the severity of these findings and the maxim that visible blood in the urine is a malignancy until proven otherwise and notified Mr. Cary that he was initiating a referral to urology and medical oncology to be performed within 72 hours ("urology and oncology will be calling you to set up appointments to further evaluate the blood in your urine and the mass on your kidney and in your liver"). Dr. Eric B. Schmell, M.D., the interpreting physician for Valor Teleradiology, noted "the findings could represent a renal cell carcinoma with hepatic metastases. A CT with IV contrast is recommended for further evaluation." Computed tomography or "CT" is the standard medical test that can reveal die presence of life-threatening malignancies in patients presenting with blood in their urine that cannot be seen in a conventional X-ray. Proper administration of the appropriate CT Imaging with and without Intravenous Contrast is crucial to the detection of renal cell carcinoma. b. The same morning, January 3, 2011 at approximately 4:21 a.m., Dr. Camilo Tabora, M.D. confirmed Dr. Goebel's directive by noting tire following: "patient found to have a 3.2 cm left renal mass and 3.8 cm hepatic mass suspicious for cancer. Patient needs work up. Referred to urology and oncology." However, five hours later, or at 9:12 a.m., Dr. Robert Sarazen, M.D. dictated the following: "Reviewed ER note. Urology consult canceled. I have ordered labs, CT scan of chest/abdomen/ and pelvis. Will have the patient come in for evaluation ASAP."

### Issue #1

When Dr. Robert Sarazen, M.D., who never examined Mr. Caery, never spoke with Mr. Carey, never spoke with the Doctors who examined Mr.Carey, and still canceled Mr.Carey's consult from Doctors who did examined the patient, was not done in the best interest of patient Cary, but part of the VA's cost-saving scheme. Dr. Sarazen's actions were reckless and callous and violated Dr. Sarazen's oath and ultimately cost Mr. Cary his life.

#### Issue #2

The VA also uses nurses and non-licensed medical staff to cancel consults from Licensed Doctors. This practice by the VA is a direct threat to the lives of Veterans. It will be proven that this practice is done with reckless disregard to the current health issues of Veterans in order to save money for the VA. Dr. Komanduri, Chief of Staff of the VA Southern Nevada Health Care System has full knowledge of this practice that has led to the deaths and further damage to patients through unnecessary delays.

Stephens's family filed a claim (before filing their lawsuit) with the VA seeking help, which was denied. The VA has failed to help his family since his death.

Attorney Paul Padda took the case and filed a lawsuit against the VA in U.S. Federal District Court and is awaiting a trial date. The Doctors who failed Stephen continue to work at the VA today.

360Daily.net reached out to the VA for comment on this story but they refused to comment.

President Trump recently signed the VA Accountability Act providing more authority to fire VA personnel.

Currently, the life of a Veteran is only worth \$350,000 under caps here in Nevada and that's before attorney fees.

The complaint accuses Dr. Komanduri of displaying:

"Gross Negligence,

Intentional Disregard for the safety of patients

Failure to Supervise Medical Staff

Failure to provide reasonable medical care

Failure to put the best interests of patients first.

Failure to timely following up in a medically necessarily timely manner following a medical issue with the patient."

The complaint also listed several other cases in which Dr. Komanduri failed to provide proper medical supervision. The complaint goes on to state that "Dr. Komanduri has refused repeatedly to take phone calls from veterans who have serious medical issues and who cannot gain access to medical care due to the incompetent bureaucracy that is creating medically lethal delays. Delays he could remedy with one phone call to his staff."

If you have been mistreated by the VA please contact the Nevada Medical Med Board and file a complaint today.

Rob Lauer

**US Army Veteran** 

Political Reporter

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CHRISTIAN MORRIS
PERSONAL INJURY TRIAL ATTORNEY

NETTLES LAW FIRM

